



Texas Conservative Coalition Research Institute

Comments to the House Committee on Human Services
Response to Request for Information
September 25, 2020

Provided via email to Assistant Committee Clerk Courtney DeBower, at Courtney.DeBower_HC@house.texas.gov.

Regarding the charge on Health Care Access and Medicaid: Examine innovative approaches and delivery models to reduce health care costs for both patients and taxpayers, including policies that other states have implemented. Consider recommendations to implement such models. Study the impact that "direct care" health care models may have on Medicaid beneficiaries for acute care and mental health services, including potential cost savings and improvement in quality metrics. Examine efforts other states have made seeking to implement direct care models, particularly in Medicaid or in charitable health care delivery.

Medicaid Program Overview

At approximately 27% of the entire state budget, with a total FY 2020-2021 biennial appropriation of \$66.4 billion all funds (AF), the Medicaid program is one of the single largest cost drivers for the State of Texas.¹ In June 2020, the most recent month reported on the Health and Human Services Commission (HHSC) website, the Texas Medicaid program was serving about 4.2 million Texans.² The program currently covers low-income pregnant women; children; the elderly; individuals with disabilities; and some parents/ caretakers of children on Medicaid. Texas Medicaid does not cover any abled-bodied childless adults. Because the program is an entitlement with open-ended funding, and is largely ruled by federal laws and regulations, the state has somewhat limited control in curbing Medicaid population growth and costs.

There are generally three major areas that drive costs in the Medicaid program. These are caseload, benefits, and provider rates, and, unfortunately, none provide a quick and easy path to meaningful reform or cost savings. The largest of these cost-drivers is caseload; however, Texas largely covers only federally mandated populations,³ leaving little room to achieve budget savings by decreasing enrollment. The state does cover some optional benefits, with one of the largest being prescription drugs.⁴ While the prescription drug benefit is responsible for a relatively significant portion of program costs, there is no question that coverage of medications provides cost offsets in the form of better managed acute and chronic health conditions that help increase health outcomes and keep Medicaid enrollees out of emergency rooms. Most of the other optional

benefits covered by Texas meet a similar threshold. The last major driver, provider rates, is also difficult because in many cases, Medicaid reimburses providers below normal commercial insurance and Medicare rates.

Given the inherent challenges in achieving any true reform and cost savings within Medicaid, state leaders are left to develop innovations that are built to achieve the aforementioned lofty goals, all while remaining within the confines of federal policy. One pathway that has received national attention over the past several years, and which both the federal Centers for Medicare and Medicaid (CMS) and Texas have embraced, is testing new delivery and payment models aimed at achieving efficiencies, improving health outcomes, and lowering costs.⁵

History of Texas' Medicaid Program Delivery Systems

In order to best examine opportunities to bring more innovation to Texas Medicaid, it is helpful to first explore a brief history of the various delivery models that have been utilized as the program has matured.

Fee-for-Service (FFS)- The most basic form of Medicaid service delivery is a fee-for-service (FFS) system. Prior to the 1990s, all Texas Medicaid recipients received benefits in an FFS system. In this environment, a Medicaid enrollee is responsible for locating and coordinating his or her own care. The state contracts directly with providers and pays claims, but there is generally little, if any, utilization review or prior authorization processes typically seen in a private sector insurance market.⁶ This also means that care can be fragmented, resulting in enrollees receiving duplicative and/or unnecessary services, as there is no major focus on care coordination or appropriate utilization.⁷

Primary Care Case Management (PCCM)- In 2006, Texas implemented a new Primary Care Case Management (PCCM) model.⁸ The crux of this program was assigning enrollees to a primary care provider (PCP) to help “manage” the patient’s care for a nominal monthly payment. While the model utilized some principles borrowed from a managed care approach, all payments to providers were still made on a volume-based claims system directly from the state.⁹

Medicaid Managed Care - Texas began implementing pilot projects using a fully risk-based capitated managed care arrangement in the mid 1990s “in response to rising healthcare costs and national interest in ways to provide quality healthcare.”¹⁰ Over the years the Medicaid managed care program has grown to completely replace PCCM and has almost entirely phased out FFS due to its success in delivering higher quality health care outcomes and helping to control Medicaid costs. Today the program operates statewide and serves over 90% of the Texas Medicaid population.¹¹

HHSC contracts with Medicaid managed care organizations (MCOs) and pays them a capitated per member per month (PMPM) premium to ensure that Medicaid recipients receive all necessary and appropriate services. Health plans are at risk for facilitating the provision of an enrollee’s services within the PMPM rate. MCOs must also maintain provider networks that ensure their members’ access to all types of care, e.g. physician, hospital, pharmacy, therapy, etc.¹² Unlike FFS, managed care plans must also meet specific access standards, such as how far members must travel to see a provider and how long it takes to get an appointment.¹³

Innovations and Value-Based Purchasing Arrangements Within Managed Care

One of the most notable advantages that the managed care model brings to the Medicaid system is its nimbleness and ability to simultaneously test new programs and ideas (i.e. delivery systems, payment models, etc.) much faster and more easily than a FFS system. A prime example of the types of reforms that can be tested via this model are value-based purchasing (VBP) arrangements. VBP, sometimes also referred to as value-based programs, permit MCOs to create special arrangements with providers to share in some of the risk associated with caring for Medicaid enrollees, allowing providers to earn payment incentives if they meet specified quality metrics.¹⁴ Quality metrics vary depending on the population served and program goals, but might include measurable outcomes such as reducing inappropriate emergency room (ER) visits, better management of chronic diseases like diabetes or asthma, or reducing the rate of hospital-acquired infections.

Texas was an early-adopter of such reforms, with HHSC producing a [Value-Based Purchasing Roadmap](#) in 2017. In this plan, HHSC explains how it is leveraging the managed care model and VBP to effect real reforms:

Through its managed care contracting model, HHSC is making progress on a multiyear transformation of provider reimbursement models that have been historically volume based (i.e., fee-for-service) toward models that are structured to reward patient access, care coordination and/or integration, and improved health care outcomes and efficiency. In concert with other policy levers, VBP has the strong potential to accelerate improvement in health care outcomes and increase efficiency.¹⁵

As part of the larger movement to VBP within the Medicaid managed care program, HHSC operates multiple programs and initiatives to improve the quality of care provided to enrollees and help contain costs. These include holding a portion of MCO capitation rates at risk based on outcomes-based performance measures; requiring MCOs to move towards value-based models with a certain percentage of network providers; and increased payments to nursing facilities that meet defined performance metrics.¹⁶

Direct Care in Medicaid

One delivery model that has gained traction in private sector health care over the past few years is direct primary care, or DPC. Under this model, patients directly pay their provider(s) a set agreed-to sum in exchange for a guaranteed set of services from that provider.¹⁷ Texas has recognized the importance of the DPC model, first adopting [HB 1945](#) (84R), which defined direct primary care in state statute and specifically established that this model does constitute an insurance product.

This option can be attractive to providers who want to “cut out the middleman” and not go through a third-party payer system. Like some catastrophic plans, this option is likely most viable for individuals and families who are, for the most part, healthy and do not anticipate many ancillary medical costs.¹⁸ It is important to note, though, that the very qualities that make direct care an important option in the private sector do not necessarily translate to the Medicaid system.

From the perspectives of the State and its Medicaid enrollees, it is doubtful that direct care would look a lot different than the FFS model in which patients are responsible for facilitating care with no coordination or case management services. While this might be a reasonable option for generally “healthy” patients, care coordination can be crucial for individuals with chronic health conditions and those who are medically fragile, many of whom are enrolled in Medicaid in Texas. By placing enrollees back into a FFS-like system the state would also lose its ability to ensure that services are not being duplicated and enrollees are not receiving unnecessary care.

Building on the challenges associated with a return to an FFS world, perhaps the most critical challenge to direct care in Medicaid revolves around the lack of ability to control utilization and costs. While states have the authority to limit amount, duration, and scope of some mandatory benefits, they must cover those services required by the federal government. A direct care model only offers the services within the scope of that provider. Any ancillary services (i.e. labs, x-rays, prescription drugs, hospital stays) are not covered by this arrangement. So, while a Medicaid enrollee could theoretically enroll in a direct care practice (with the state paying the cost of that arrangement), that recipient is still entitled to any and all mandatory Medicaid services, which the state would also be required to provide. It is doubtful that CMS would have the willingness, or even the authority (short of Congressional action), to allow states to limit mandatory benefits. This inability to limit services or benefits would severely hinder any motivation for patients to self-regulate utilization and contain costs. Therefore, there is a very likely chance that this model could result in a greater number of unnecessary services and increased costs that would be borne by the state and its taxpayers.

There is no question that direct care has a key role in the private sector, allowing consumers who choose to enter into a direct agreement with the provider(s) of their choice. However, as an entitlement program, Medicaid is fundamentally different than the private sector and, as such, must rely on care coordination and other program controls to ensure taxpayer dollars are being used judiciously and enrollees are receiving quality care.

Conclusion

Texas has long been at the forefront of seeking out and implementing innovative reforms that better serve our state’s Medicaid enrollees and bend the program’s cost curve. From rolling out Medicaid managed care statewide and negotiating the historic 1115 Transformation Waiver, to moving the system towards one that rewards quality outcomes over volume, our state has done an admirable job in bringing private sector innovation and accountability to a massive entitlement program. And, while much has been accomplished, there are certainly more improvements that can be made.

The benefit for Texas is that we have already fully embraced the Medicaid managed care system, which remains one of the most effective means of providing high-quality cost-effective coverage. Health plans are generally able to provide better care by helping coordinate care and direct enrollees to more preventive, lower-cost settings and by utilizing the providers within their networks. By only contracting with certain providers, MCOs, just like those in the private sector, have the opportunity to negotiate lower prices and, most importantly, adopt standards that may restrict lower-quality providers from joining their networks.

State leaders should continue to move fully away from the vestiges of the inefficient FFS system and leverage the managed care model to test and implement payment and delivery models based on quality and cost controls.

About TCCRI

The Texas Conservative Coalition Research Institute (TCCRI) was founded in 1996 by a group of state leaders determined to implement conservative public policies in state government. TCCRI has distinguished itself as a leading state-based think tank and has been very successful in living up to its mission of shaping public policy through a principled approach to government. Its research reports, Task Forces, and policy summits have been instrumental in generating proposals that are shaping Texas government and influencing a new generation of conservative leadership.

The work of TCCRI is based upon four core principles: Limited Government, Individual Liberty, Free Enterprise and Traditional Values. Together, they form our LIFT principles and underpin all TCCRI Task Forces, conferences, and publications. Each principle guides our Board and Staff.

ENDNOTES

¹ Legislative Budget Board. “Fiscal Size Up 2020-21 Biennium.” May 2020. Available at: http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp.pdf.

² See HHSC website. “Medicaid and CHIP Enrollment by Risk Group (September 2014- June 2020).” Available at <https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics>.

³ Health and Human Services Commission, “Texas Medicaid and CHIP in Perspective.” Twelfth Edition. December 2018. Available at <https://hhs.texas.gov/reports/2018/12/texas-medicaid-chip-reference-guide-twelfth-edition-pink-book>.

⁴ *Ibid.*

⁵ CMS Informational Bulletin. “Delivery System and Provider Payment Initiatives Under Medicaid Managed Care Contracts.” November 2, 2017. Available at: <https://www.medicare.gov/sites/default/files/federal-policy-guidance/downloads/cib11022017.pdf>.

⁶ Kaiser Family Foundation. “Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts.” June 22, 2015. Available at: <https://www.kff.org/medicaid/fact-sheet/medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts/>.

⁷ *Ibid.*

⁸ Texas Health and Human Services Commission, “Texas Medicaid and CHIP Reference Guide,” Twelfth Edition, December 2018, available at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/medicaid-chip-perspective-12th-edition/12th-edition-complete.pdf>.

⁹ See Texas Medical Association website. “PCCM: What Is It?” Available at: <https://www.texmed.org/Template.aspx?id=2144>.

¹⁰ Texas Health and Human Services Commission, “Texas Medicaid and CHIP Reference Guide,” Twelfth Edition, December 2018, available at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/medicaid-chip-perspective-12th-edition/12th-edition-complete.pdf>.

¹¹ *Ibid.*

¹² *Ibid.*

¹³ *Ibid.*, p. 129-130.

¹⁴ See CMS website. “What are value-based programs?” Available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs>.

¹⁵ Texas HHSC. “HHSC Value-Based Purchasing Roadmap.” June 2017. Available at: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/1115-waiver-draft-vbp-roadmap.pdf>.

¹⁶ Texas HHSC. “Delivery System Reform Incentive Payment (DSRIP) Transition Plan.” August 27, 2020. Available at: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/dsrip-transition-plan.pdf>.

¹⁷ American Academy of Family Physicians. “Direct Primary Care.” Available at: <https://www.aafp.org/about/policies/all/direct-primary-care.html>.

¹⁸ Hoff, Timothy J., PhD. “Direct primary care has limited benefits for doctors and patients.” September 6, 2018. Available at: <https://www.statnews.com/2018/09/06/direct-primary-care-doctors-patients/>.